State Mississippi

DEFINITION OF A CLAIM

- For hospital outpatient, physician, dental, prescribed drugs, home health services, and clinics, a claim is a line item with an associated charge to be adjudicated.

- For hospital inpatient services, a claim is a separate hospital billing issued for all or a portion of the inpatient hospital stay. When a single hospital billing is comprised of more than one document, the billing should be counted as a single claim.

- A nursing home claim is defined as one claim per month per recipient stay. Recipient stay is defined as consecutive days in a nursing home at the same level of care.

- EPSDT claim is defined as one claim per line item.

- Cross-over claims are defined as the cross-over billing item.

TN No. 87-11 DATE/RECEIPT 6/1/87
SUPERSEDES DATE/APPROVED 6/23/87
TN No. 79-19 DATE/EFFECTIVE 4/1/87

# STATE OF MISSISSIPPI

# OFFICE OF THE GOVERNOR

# DIVISION OF MEDICAID

## STATE PLAN

## GUIDELINES FOR THE REIMBURSEMENT

## OF COSTS FOR SERVICES

## TO MEDICAL ASSISTANCE RECIPIENTS

## FOR

## FEDERALLY QUALIFIED HEALTH CENTERS

Transmittal 90-08

TN 90-08 SUPERSEDES
TN NEW

DATE RECEIVED SEP 2
DATE APPROVED 11/12/92
DATE EFFECTIVE 8/21/90

## INTRODUCTION

This manual is for use by providers, their accountants, the Division of Medicaid, and its fiscal agent in determining the allowable and reasonable costs of Federally Qualified Health Center services furnished to Medicaid recipients. The manual contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Division of Medicaid. These procedures will be used in determining reimbursement to the provider of its allowable and reasonable costs.

The program herein adopted is in accordance with Federal Statute in the Social Security Act Section 1905(a) and (1) and Section 1902(a)(13)(E). There are no Federal Regulations for Medicaid for Federally Qualified Health Centers. Each community health center which has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this manual; each must file the required cost reports and will be paid for the services rendered on a rate related to the allowable and reasonable costs incurred for care and services provided to Medicaid recipients for core services and the fee-for-service rate for non-core services. Payments for services will be on a

retrospective basis as cost settlement will be executed for each cost reporting period.

In adopting these regulations, it is the intention of the Division of Medicaid to pay one hundred percent of the allowable and reasonable costs of covered services rendered to Medicaid recipients.

As interpretations and changes of this program are made, appropriate revisions of this manual will be furnished to each provider and interested parties. Care should be taken to insure that revisions to the manual are promptly inserted.

Questions relating to the implementation of this program or relating to the interpretation of any of the provisions included in this manual should be addressed to:

Division of Medicaid
Suite 801, Robert E. Lee Building
293 North Lamar Street
Jackson, Mississippi 39201-1399

# TABLE OF CONTENTS

INTRODUCTION





TN 90-08 DATE RECEIVED SEP
SUPERSEDES DATE APPROVED 11/13/92
TN NEW DATE EFFECTIVE
AUG

TN 90-08 SUPERSEDES
TN NEW
DATE RECEIVED SEP 2
DATE APPROVED 11/13/92
DATE EFFECTIVE AUG 21

# CHAPTER 1

## PRINCIPLES AND PROCEDURES

### 1-1 REIMBURSEMENT PRINCIPLES AND PROCEDURES

All Federally Qualified Health Centers (FQHC) will be reimbursed according to the principles and procedures specified in this plan. Allowable costs are those costs necessary and reasonable for performance of covered services required by Medicaid recipients.

### A. General Principles

A FQHC's direct and indirect allowable costs related to covered services will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible recipients. Total allowable, reasonable costs for a center shall be apportioned between third party payors and other patients so that the share borne by Medicaid under Title XIX is based upon actual services and cost related to medical assistance recipients.

### B. Cost Reporting

All FQHC's will submit cost reports to the Division of Medicaid using a standard year end of June 30. Standard year end cost reports should be filed from the date of the last report. Each center must submit a completed cost report, in duplicate, on or before the last day of the fifth month following the close of the

reporting period. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday.

An extension of time for filing, not to exceed fifteen (15) days, may be granted by the Division of Medicaid. In order to receive an extension, a request must be made in writing. The request must be postmarked or faxed to the Division of Medicaid on or before the due date of the cost report. The fifteen (15) day extension shall begin the day after the original due date of the cost report, regardless of whether the original due date was on a weekend or a state or federal holiday. Should the extended due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the extended due date shall be the first business day following such weekend or holiday.

Cost reports that are either postmarked or hand delivered after the due date will be assessed a penalty in the amount of $50.00 per day the cost report is delinquent. This penalty may only be waived by the Director of the Division of Medicaid.

All cost reports and supporting files will be maintained by the health center and the Division of Medicaid for a period of five (5) years after submission. The health center will consider for cost finding allowable direct, indirect and related organization costs applying to Medicaid recipient care. The reasonableness of all allowable costs will be based on HIM 15 standards except as otherwise described in this manual. Allowable costs will be accounted for in accordance with generally accepted accounting principles.

Providers are required to maintain adequate financial records and statistical data for proper determination of costs payable under

the program. The cost report is to be based on financial and statistical records maintained by the provider. Cost information must be current, accurate, and in sufficient detail to support cost set forth in the report. This includes all ledgers, books, records and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, basis of apportioning costs, etc.) which pertain to the determination of reasonable costs, and must be in condition for and available to State and Federal audit authorities.

C. Cost Apportionment and Allocation

The allowable costs for Federally qualified health center care are apportioned to the Medical Assistance Program by multiplying the FQHC cost per visit by the number of eligible visits of care of medical assistance recipients. Cost settlement will be performed on an annual basis to ensure that the FQHC's receive 100% of reasonable costs for providing allowed services to medical assistance recipients.

D. Cost Containment and Management Efficiency

The Division of Medicaid has adopted the percentile limitation of reported overhead costs of the facility, administration and management of the health center as the basis for screening